Program Description

Mission and Authority

The mission of the Indian Health Program (IHP) is to improve the health status of American Indians/Alaska Natives (AI/AN) living in urban, rural, and reservation or rancheria communities throughout California.

Health services for American Indians are based on a special historical legal responsibility identified in treaties with the U.S. government. California voluntarily accepted this responsibility by adopting Public Law (P.L.) 83-280 in 1954, which allowed for State jurisdiction of Indian affairs. The current legislative authority for the program was entered into law by Senate Bill (SB) 1117 in 1983, and recodified in the Health and Safety Code, as Sections 124575 - 124595 by SB 1360 in 1995.

Population Characteristics

According to the 2000 U.S. Census, there were 627,562 American Indians living in California. This included 333,346 people who classified themselves as AI/AN and an additional 294,216 classified themselves as AI/AN and one or more other races.

The AI/AN population in California is comprised of members of indigenous California tribes as well as members of tribes from throughout the United States. There are more than 107 indigenous California tribes, representing about 20 percent of the nation's approximately 500 tribal groups.

Attitudes, beliefs, and behaviors regarding health issues and utilization of health services by the AI/AN population is influenced by cultural and social factors, as well as historical access to services. Thus, the health status of the AI/AN population in California is a reflection of the availability of acceptable, appropriate health services and the utilization of these services.

Historical Overview of Health Services

U.S. treaty provisions guarantee health and social services to American Indians. However, the development of a Federal Indian Health Service (IHS) system in California was slow and fragmented as a result of eighteen treaties signed but not ratified. Consequently, Federal health resources to the State between the mid 1850's-1950's were almost nonexistent, consisting of several small sanitation projects, TB sanitariums, and two hospitals located in isolated areas.

A series of federal and state reports documented alarming deficiencies in the health status of Indians. A report issued by the California Indian Commission in 1963 reported rates of T.B., infant mortality, alcoholism, diabetes, and other diseases higher than rates for the general population. This report prompted activity within the Department of Health Services (DHS) in regards to Indian health. Small demonstration projects were conducted with support of federal Maternal and Child Health (MCH) monies and a temporary office of Indian Health was established in 1969.

The office assisted Indian communities to organize local primary care clinics, eventually resulting in the establishment of a network of such clinics throughout the state. A community Board of Directors or Tribal Council governs each clinic. The passage of SB 52 in 1975 represented the first efforts of the Legislature to directly address Indian health. SB 52 directed DHS to create an Indian health branch with a budget to conduct local programs. The branch was reduced to program status in 1983 as part of the Rural Health Act (SB 1117).

Historical Overview of IHP Funding

The allocation of funds to Indian health clinics in California has its origin in legislation passed and signed by the Governor in 1975 (SB 52). Each year the proposed funded amount is indicated in the Budget Act.

Indian health clinics receive funding through an allocation formula every year. Additionally, each fiscal year, funds may be set aside for special projects. If this occurs, the IHP receives recommendations from the American Indian Health Policy Panel regarding the amount and purpose of these projects. Special projects are awarded through a competitive Request for Application (RFA) process. Final approval comes from the Branch and Division Chiefs.

The $6,464,000 IHP budget from state general funds for Fiscal Year (FY) 2004-2005 was distributed as follows: $6,084,000 was distributed to 29 primary care clinics through the allocation formula, described in further detail in a separate section. Two health organizations received $30,000 each to provide regional traditional Indian health education programs for Northern California and Southern California. A set aside of $320,000 was also appropriated to support the development of an American Indian health clinic in Los Angeles County.

Other than a 4% decrease in 1991 and a 65% cut in program staff support in FY 1991-1992, the IHP budget experienced few changes. In 1995-1996 the IHP budget was augmented by 1 million dollars. This 35 percent increase resulted in a $3,876,000 budget for the IHP in FY 1996-1997.

In FY 1999-2000, the IHP received a 2 million dollar budget augmentation resulting in total IHP funding of $5,876,000.

In FY 2000-2001, the IHP received an additional increase of $588,000 (10 percent of the previous year's final budget amount), which resulted in the current annual allocation of $6,464,000.

From 1980-1993, IHP funds were distributed to the same group of clinics. In FY 1993-1994 legal considerations prompted a policy to open the program to all eligible Indian clinics every fourth year through a RFA process. Since then the IHP has funded about a dozen additional clinics.

Health Status

In 2000 a total of 2.5 million persons (0.9% of the U.S. population) classified themselves as American Indians/Alaska Natives (AI/AN) alone and 4.1 million (1.5%) classified themselves as AI/AN alone or in combination with another race. Approximately 26 percent of AI/AN lived in poverty, which was twice the national rate and the highest poverty rate of all racial/ethnic populations.

AI/AN experience persistent socioeconomic burdens and significant health disparities in their rates of diabetes, cancer, injuries, and pulmonary diseases.

Statistics that reflect the overall low health status of American Indians in California include:

- 16 percent of American Indian births in 2002 were to teen moms compared to 10 percent for Whites.

- There were 8.1 deaths per 1000 American Indian live births in 2001 compared to 4.7 for Whites. This rate discrepancy was probably even higher though as it does not include the finding of an IHP study that showed misclassification on death certificates for American Indian children under age 15 was three to four times greater than reported in state mortality data.

- 74 percent of American Indian mothers in 2001 received first trimester prenatal care as compared to 90 percent for Whites.

- Diabetes prevalence for ages 50-64 is consistently higher among AI/AN (19.6%) as compared to Whites (8%).

- AI/AN with diabetes have a high incidence of diabetes complications such as eye, kidney, lower extremity amputations, and cardiovascular disease. Cardiovascular disease was the leading cause of death in AI/AN and diabetes is a high contributing risk factor for cardiovascular disease.

- Diabetes mellitus is one of the most serious health challenges facing AI/AN in the United States today. Diabetes contributes to several of the leading causes of death in American Indians - heart disease, cerebrovascular disease, pneumonia, and influenza. On average, AI/AN are 2.6 times as likely to have diabetes as non-Hispanic whites of a similar age.

- From 1999 through 2001, AI/AN had significantly higher average death rates due to chronic liver disease and cirrhosis.

- From 1999 through 2001, AI/AN females in California had the highest average death rate from accidents. Injuries cause 75% of all deaths among Native Americans age 19 and younger. The overall death rate from preventable injuries remains nearly twice as high for native people as for the general population.

Program Activities

Statute directs the Department of Health Services to address the comparatively low health status of American Indians through maintenance of a program consisting of all of the following:

- **Technical and financial assistance to local agencies concerned with the health of American Indians and their families.**

  Supported by an annual general fund budget of 6.4 million dollars the IHP maintains grant agreements with 29 Indian health clinics in urban, rural, reservation and rancheria communities throughout California to provide primary care services to American Indians and other underserved populations. Technical assistance is provided to all IHP clinics in the form of quality monitoring and consultation by IHP staff. During 2003, IHP clinics provided medical services to 43,938 AI/AN and dental services to 27,718 AI/AN. In addition, IHP funds and administers two Traditional Indian Health Education grants that provide an opportunity for annual forums in both northern and southern California. The IHP also provides special funding for the development of primary care services in Los Angeles County. To address the need for maternal and child health services IHP created the American Indian Infant Health Initiative, funded by Title V MCH funds and administered by IHP. A confidential HIV testing and counseling program is also administered by IHP.

- **Studies of the health and health services available to American Indians and their families throughout the state.**

  The Indian Health Program has participated in a Congressionally mandated statewide report regarding the health status of non-federally recognized Indians, and a national study regarding the impact of managed care on Indian health services delivery systems, and a study with the IHS and UCSF that showed that misclassification on death certificates for American Indian children under age 15 was three to four times greater than reported in state mortality data.

- **Coordination with similar programs of the Federal Government, other states, and voluntary agencies.**

  IHP routinely serves as a liaison with other programs within DHS such as MCH, Emergency Preparedness, and Medi-Cal on behalf of IHP clinics. IHP staff communicates with IHS, U.S. Department of Health and Human Services-Centers for Medicare and Medicaid Services, and a myriad of community based organizations. IHP was instrumental in the development of Medi-Cal Managed Care regulations that are specific to American Indian clients and in managed care plan reimbursement to American Indian clinics.

Additional Program Components

American Indian Health Policy Panel (AIHPP)

The AIHPP provides advice to DHS and IHP on Indian health. The AIHPP is composed of four members representing rural areas, four members representing urban areas, and two community members-at-large. Panel members are nominated by their respective communities appointed by the Director and serve a two-year term. The AIHPP meets annually.

American Indian Infant Health Initiative (AIIHI)

IHP was allocated $424,00 of Federal Title V MCH funds to implement an intensive home visitation program for high-risk pregnant or parenting families Public Health Nurses (PHNs) supervise AI/AN home visitors serving families in five counties with the most severe Indian MCH health disparities. Home visitors and PHNs provide families basic health education and needed referrals for a variety of community resources.

Human Immunodeficiency Virus (HIV) Antibody Testing and Counseling

IHP administers HIV testing and counseling funds through a Memorandum of Agreement with the State Office of AIDS (OA). Funds are distributed annually to Indian health clinics through a competitive process. HIV grantees provide confidential testing and counseling services to AI/AN in urban and rural California. Clinics may offer the standard blood test, the new oral test, or same day results with the new OraQuick finger stick blood test.

Traditional Indian Health

IHP administers two Traditional Indian Health Education grants, one in Southern California and one in Northern California. These grants provide an opportunity for AI/AN and Indian clinic staff to learn about traditional health beliefs and practices. Gatherings are held annually in Northern and Southern California.

Los Angeles County

The IHP provides special funding for an effort to establish an American Indian health clinic in Los Angeles County, home of the largest urban AI/AN population in California.

Clinic Funding via the Allocation Formula

IHP primary care funds are distributed in compliance with SB 1117 according to a need and performance driven formula. Below is a description of each of the five IHP allocation formula factors weighted according to their relative importance.

Factor 1:

Systems Evaluation (46% of the allocation formula): This factor is based on the biennial in-depth, on-site evaluation of the quality of a clinic's Medical, Dental, Community Health Services and Board / Administrative / Fiscal systems. Based on scores achieved, funding levels for each clinic are then determined relative to their evaluation results.

Factor 2:

Foundational Criteria (22%): A clinic eligible for IHP funding must provide at least two of the following three components: Medical, Dental and Community Health Services. Funds provided in this factor are distributed in equal portions to each grantee. If any of the three components are not provided, the following percentages are applied as deductions to the equal portion.

Medical: 40% Dental: 30% Community Health Services: 30%

Factor 3:

Grant Objectives (15%): This factor measures how well grantees have met the numerical objectives in their grants. Grant objectives are calculated for each clinic based on the number and type of staff providing their Medical, Dental and Community Health Services. Data to measure achievement of grant objectives are obtained from **visits** reported on the Monthly Progress Reports submitted by clinics.

Factor 4:

Population Service Index (15%): Funding for this factor is based on the number of AI/AN **patients** actually served during the calendar year in both the medical and dental programs by each clinic. Data to measure this factor are also obtained from the Monthly Progress Reports submitted by clinics. A per capita rate based on the unduplicated patients served by each grantee determines the funds awarded for this factor.

Factor 5:

Target Population (2%): This final factor recognizes the size of the AI/AN population in a clinic's service area. The population figures used primarily are from estimates of the service area population prepared by the Federal Indian Health Service and also the U.S. Census Bureau. A per capita figure determines the funds awarded for this factor.

Contact Information

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